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Volume 1, Issue 2 Spring 1990

Montana Health Promoter

Newsletter of the Chronic Disease Prevention and Health Promotion Program
Montana Department of Health and Environmental Sciences

Heart Disease:
Active Lifestyles Protect Montanans

by Marsha McFarland

Many studies have demonstrated that certain characteristics and behaviors of individuals are associated with an increased risk for heart disease. Some of these risk factors such as increasing age, being male, or family history of heart disease cannot be changed. But a number of major risk factors are behaviors which are within the control of the individual. And the chances of incurring heart disease can be reduced dramatically by making changes in personal habits. Questions about these risk behaviors are asked of 99 Montanans each month in a telephone survey conducted by the Department of Health and Environmental Sciences, through a cooperative agreement with the Centers for Disease Control, Atlanta, Georgia.

Smoking

Smokers have more than twice the risk of heart attack as non-smokers. A smoker who has a heart attack is more likely to die from it and is more likely to die within an hour, than a non-smoker.

When smokers quit, regardless of how long or how much they have smoked, the risk of heart disease declines rapidly. Smokers who stay quit for ten years after smoking a pack a day or less have nearly the same risk of heart disease as people who have never smoked.

During 1988, 19.8% of Montanans reported that they were current smokers. This continues a declining trend of adult Montanans who smoke, although the percent of Montanans who have ever smoked has remained fairly constant, (nearly 49%) since 1984. Montanans who are most likely to smoke have experienced difficulties in areas of life, such as marriage and employment, which are deemed highly important in society.

Hypertension

High blood pressure causes the heart to work harder and as a result can enlarge and weaken the heart over time. Although high blood pressure has no symptoms, a quick medical evaluation can detect it. In combination with other risk factors, including smoking, high cholesterol, or diabetes, the risk of heart attack or stroke increases several times.

Data obtained through Montana's Behavioral Risk Factor Surveillance System (BRFSS) suggests that approximately one Montanan in five has been told by a health professional that they have high blood pressure. Since high blood pressure is symptomless, it is possible that other Montanans have high blood pressure, but don't know it. Of Montanans who know they have high blood pressure, those who are most affected are the elderly, retired, and the widowed.

High Cholesterol

As blood cholesterol levels rise, so does the risk for coronary heart disease. Combined with the presence of other risk factors, this risk becomes even greater. Cholesterol is used by the body to build cell walls, and the liver is able to produce sufficient cholesterol for the body's

continued on page 2

In this Issue

Shortcuts to Good Health? 4
Heart healthy resource materials 7
Heart patient makes strong comeback 5
Funding Facts 6

PLEASE RETURN

From the Editor

In 1984, the U.S. Public Health Service convened a Preventive Health Services Task Force representing a non-federal body of experts charged with reviewing the scientific evidence for a variety of recommended clinical preventive services. The report, published in 1989 and entitled, "Guide to Clinical Preventive Services," is the culmination of over four years of literature review, debate, and synthesis of critical comments from expert reviewers. It offers the task force members' best judgement, based on the evidence, of the clinical preventive services that prudent clinicians should provide their patients in the course of routine clinical care.

The task force recommended that physicians spend more time counseling patients on healthy living and less time doing routine screening tests. The group also concluded that some tests are ineffective as routine screening tools and should be used only on patients with symptoms or at high risk for the disease.

Dr. Robert S. Lawrence, task force chairman and director of primary care at Harvard Medical School, stated "The data show that efforts by clinicians to influence health behaviors—such as smoking, diet, physical activity, abuse of alcohol and other drugs—and unsafe practices, such as riding in a car without using a safety belt—are more likely to reduce morbidity and mortality in this country than any other category of clinical intervention."

The findings suggest that the roles of both clinicians and patients will continue to undergo important changes in the near future as patients assume greater responsibility for their own health, and clinicians develop new skills in risk assessment, counseling, and patient education.

If the change is to occur, the fee-for-service system must acknowledge the value of preventive strategies in reimbursement. Dr. Lawrence said "If doctors aren't paid for urging patients to stop smoking, but are paid for treating myocardial infarctions, no wonder most doctors focus on treating the MI." Money incentives are part of the formula, but human behavior change with the population most in need is a challenge.

The task force recommendations are being highlighted here because many of the risk factors and preventive services have the potential to decrease the mortality and morbidity due to cardiovascular diseases.

Robert W. Moon, M.P.H.
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Heart Disease, *continued from page 1*

needs. Cholesterol taken into the body through diet contributes to excess cholesterol levels in the blood.

Consumption of saturated fat and cholesterol tends to raise the level of cholesterol in the blood. A diet low in saturated fat and cholesterol usually results in lower levels of blood cholesterol. By making appropriate food choices, people will help minimize the tendency for cholesterol levels to rise with age. Thus it is important for blood cholesterol in healthy adults to be measured at least every five years.

The BRFSS has included questions about Montanans' knowledge of their cholesterol levels since 1987. Nearly 55% indicate that their blood cholesterol has been checked. Montanans who are least likely to have had their cholesterol levels checked are adults aged 18-39, the unmarried, homemakers and students. Knowledge of personal cholesterol levels permits those at risk to consult with their health professional and make appropriate changes that will lower cholesterol levels and reduce the risk for coronary heart disease.

Obesity

Diabetes, obesity, physical inactivity and stress are also associated with an increased risk for coronary heart disease. Obesity is unhealthy because excess weight puts an added strain on the heart. About one Montanan in five is at risk for being overweight, when overweight is defined as being more than 120% of the median weight-to-height ratio for the U.S. population. The prevalence of overweight among Montanans has changed very little during 1984-1989.

Being overweight is also related to high blood pressure and high blood cholesterol, as well as diabetes. Diabetes most often appears during middle age and among people who are overweight.

Sedentary Lifestyle

Coronary heart disease has been shown to occur twice as frequently among sedentary men as in men who regularly participated in vigorous physical activity. During the past five years, Montanans appear to have increased their involvement in physical activities outside of work. In 1984, 72.3% of adult Montanans participated in at least one physical activity; by 1988 over 80% participated in one type of physical activity. When compared with other states participating in the Behavioral Risk-Factor Surveillance System, Montana was second only to the state of Washington in the reported frequency of adults who regularly exercise at least 20 minutes 3 times a week.

Early Start for a Healthy Heart

Montanans eat too much fat! According to Project LEAN (Low-Fat Eating for America Now) almost 40 percent of the calories in the average diet come from fat. Diets high in fat have been linked to the ten leading causes of death in the United States, including heart disease and some cancers. The Henry J. Kaiser Family Foundation, in partnership with 24 national organizations, is calling for a moderate reduction in consumption of total fat as a prudent measure to lower some of the risk factors for the major chronic diseases.

Project LEAN is a national campaign to improve nutrition and reduce the consumption of dietary fat. The project has three primary objectives:

- to reduce dietary fat intake from present levels to 30 percent of calories by 1998;
- to increase availability and accessibility of low-fat foods through supermarkets, restaurants, and cafeterias in worksites and schools;
- to increase collaboration among national and community organizations committed to reducing dietary fat.

Montana kicked off the campaign with an "Early Start For A Healthy Heart" workshop in Kalispell, Montana on February 16. The one-day conference on lipids, cholesterol, and preventable cardiovascular disease was aimed at updating physicians, educators, dietitians, registered nurses, and pharmacists on cardiovascular risk reduction issues at various stages in the life cycle; encouraging improved working relationships in the prevention and treatment of cardiovascular disease; and stimulating public discussion of lifestyle issues pertaining to cardiovascular risk reduction. Particular emphasis was given to the early years as a point in the life cycle to truly influence eating habits. Wyeth-Ayerst Laboratories and the Montana Department of Health and Environmental Sciences provided financial support for the conference.

The workshop featured national and state specialists on heart disease and diet. The community of Kalispell was treated to a public forum on "Cardiovascular Risk Assessment and the Role of Nutrition in Preventing Heart Disease". More than 450 community representatives attended and heard the current ideas for "heading off heart disease and improving diet". An estimated 200 health care providers were on hand to hear how to influence what people eat.

Sonja Connor, University of Oregon, author of "The New American Diet," stated "99 percent of the health care dollar is figuratively used building ambulances to help people who have fallen off cliffs and one percent building fences to prevent such falls. Families can build their own fences to prevent heart disease and other illnesses."

If you would like to receive more information on Project Lean, contact Robert Moon, Montana Department of Health and Environmental Sciences, (406) 444-4740.

Relationship Between Cholesterol and Heart Disease

The American Heart Association and the National Heart, Lung, and Blood Institute have issued a joint statement summarizing the evidence which relates dietary fats, blood cholesterol, and coronary heart disease. The statement is intended to "remove any doubts about the direct relation between cholesterol and heart disease."

The statement reviews the epidemiologic, laboratory, and clinical studies that answer the most frequently asked questions about cholesterol: Is high blood cholesterol a risk factor for heart disease? Will lowering blood cholesterol help prevent coronary heart disease? Will you live longer if you reduce your cholesterol levels? Does cholesterol management matter if you already have coronary heart disease? Does diet make a difference? Should your age or gender change your approach to cholesterol control? Are cholesterol interventions cost-effective?

The authors conclude that numerous epidemiologic and laboratory studies have confirmed the continuous, positive correlation of elevated cholesterol levels to increased heart disease risk. Clinical studies have shown that cholesterol modification by diet or drugs can lower that risk. Cholesterol-modifying benefits are available to men and women, young and old, those with high-risk cholesterol levels and those with borderline high-risk levels. Furthermore, cholesterol interventions are cost-effective. This evidence more than justifies the current national campaign for cholesterol control.

"We haven't got a mousetrap. We're hoping the cholesterol might kill them."

Nutrition and Magic—

Shortcuts to Good Health?

by Cindy Brown, M.S., R.D.
Clinical Nutrition Supervisor
St. Peter's Community Hospital, Helena

Cindy Brown

More than ever before, Americans are concerned and curious about their health, fitness and weight. Unfortunately, nutrition and fitness are relatively new topics in the world of scientific study, leaving legitimate experts unable to prove or disprove various nutrition therapies, fitness or health crazes, or to find solutions for the continuing frustrations of the overweight population. Studies from reputable universities often contradict each other on nutritional aspects of heart disease, oat bran and caffeine being two recent examples, while there is a major debate about the efficacy and safety of the new very low calorie liquid diets.

The effect of this trend is disconcerting. Americans are growing skeptical of the validity of **any** information provided by the so-called scientific community. Yet, busier than ever with jobs, families, and leisure activities and still concerned about appearance, health and longevity, adults concerned with good health are prime targets for individuals, corporations, and industry groups who purport to have the **the** answers that science cannot provide. These groups also take advantage of that very human trait—the desire for a quick and easy solution to good health. Diet books, devices, machines, and formulas are a billion dollar industry, capitalizing on the emotional quest for the perfect body. Pills, potions, and diets to prevent or cure disease bring in millions of dollars more in the quest for a long healthy life—or at least the freedom from a terrifying disease. Since many food manufacturers became aware of the marketability of oat-containing products, for example, it seems harder to find foods that do **not** contain oat bran than ones that do. Not only are many of these foods high in sugar, salt, calories and saturated fat, but headlines describing a recent study from a major university now scream out that oat bran is, in fact, useless for lowering cholesterol levels.

Is there an answer to legitimate frustration over contradictory messages being given by health professionals? How can we carefully steer clear of those offering tantilizingly quick "solutions" to very frustrating long-term health concerns.

Remember, first of all, what we do know about nutrition and good health.

- There is no question that a diet of high-fat foods is unhealthy. Studies will continue to differ on the details: What kinds of fats are best? How much fat is too much? But for most people, the basic concept is what is important.
- Experts agree that meals high in fiber can be helpful in a variety of health-related areas. They will disagree for quite some time, no doubt, on exactly what the best type of fiber is, how much is optimal, and which type of fiber does what. But again, the basic concept will continue to be valid.
- There is overwhelming agreement that to lose weight, one must decrease the calorie content of the diet, increase exercise, and, in fact, follow the meal pattern described above—low in fat and high in fiber. There will, however, **always** be someone out there to tell us there is a quicker, easier way—a way to lose weight without exercise, without permanent lifestyle changes, and certainly a much quicker way than a few pounds a week. The basic scientific facts are, however, that these dream solutions do not exist, no matter how much both the overweight person and the health professional wish they did.

continued on page 5

Close Up

Coming back strong

by Toni Jensen

Alex McNeill

"In this culture how we look is more important than who we are," according to Alex McNeill, acting head of the Department of Health and Human Development at Montana State University in Bozeman. "If you are slim, it is assumed that you are healthy," he said. "I knew I was in good shape. I've been an athlete all my life. I also exercise regularly and watch what I eat. But looks can be deceiving, because I also had a cholesterol level in excess of 290 and didn't even know it."

"In 1985," he said, "while camping with my family, I woke up suddenly one night and was out of breath. I checked myself into a local clinic and no trace of cardiac damage was detected. After all, I was only 40 and in good shape. But the shortness of breath persisted and I had additional tests. I had an angiogram, which revealed a good oxygen supply to the heart and no apparent significant heart problems. I started taking beta blockers, a medication designed for people with impaired cardiac functioning. Unfortunately, I felt they diminished my mental acuity and I was still experiencing shortness of breath. I had always anticipated that I had 25 more years to live, but I couldn't face them without trying to do something about this problem that was beginning to seriously impair my activities."

Four weeks after the onset of his symptoms, McNeill had open heart surgery. The problem was far more severe than anyone had anticipated. One major artery was doing all the work to pump blood throughout the heart. Two other major arteries were 100% blocked. The culprit, it turns out, was heredity and McNeill underwent double by-pass surgery. "It was fortunate that I was in such good shape," he said, "I was in the hospital for 10 days and back to work in another 10 days."

"Having open heart surgery has certainly changed me," he said. "You come out of surgery with real physical and psychological effects—there is a piece of your leg in your chest. In addition, during heart surgery your heart is stopped in order to repair it and there are some physical effects as a result of this. Your vocabulary is impaired for three to six months. I had trouble retrieving words, and there was some memory impairment. You realize that you're not unmarked. I don't find that necessarily negative, although at times I feel conspicuous. I have scars on my legs—I look like I've been through a combine."

To ensure longevity, it was critical for McNeill to make additional lifestyle changes. "Shortly after the surgery, I consulted with a dietitian in order to change my eating habits to reduce my intake of dietary fat and lower my cholesterol level. I wanted to minimize the medication I would have to take and manipulate my cholesterol level through dietary changes. Now, I usually eat an assortment of vegetables (steamed) and wild game. We also eat chicken and fish. I rarely eat beef anymore, and any meat we eat is skinned and broiled—nothing is fried. The only oils we use are peanut (for Chinese cooking), olive and canola oil. We cook varied foods, enjoy stir-frying foods, and have learned to adapt high fat Mexican food recipes to low-fat cooking. As a result, I have managed to drop my cholesterol level to its current level of 170."

"Since my surgery I do more. I have minimized my limitations. Time is more important to me and I don't put things off. I live more for today. Happiness, after all, is not a destination."

Nutrition, *continued from page 4*

Nutrition, fitness, and health will continue to be "in" topics for years to come. The positive aspects, of course, are many. But, decreasing the frustration of the public and increasing the likelihood of healthy lifestyle changes will require that health professionals and especially legitimate researchers become more aware of the impact on the public of their contradictory statements and their apparent unwillingness to relate each study to present knowledge and practical usefulness. The public must at least try to understand that health experts do not have all of the answers; that health and nutrition **are** new fields where legitimate disagreement should be encouraged; and that we do know the basic elements of good nutrition and health—a balanced diet, a variety of foods, meals low in fat, and plenty of whole grains, fresh fruits and vegetables. And no matter how tempting the latest weight reduction scheme may sound, the basic law of supply and demand will always be true—eat less fat to lower calorie levels and exercise more to increase calorie use and maintain muscle mass. Nutrition is important, certainly, but it is **not** a magic solution, nor a shortcut to good health.

Guidelines

American Heart Association Recommends Guidelines for Public Cholesterol Screening.

These guidelines summarize methods that make public screening more effective in detecting high blood cholesterol in individuals who might otherwise not be identified in the health care system. The guidelines were developed by the National Heart, Lung, and Blood Institute, October 1988.

RECOMMENDATIONS

Certain criteria are necessary for public screening programs. Programs should:

- Attract adult segments of the community and reach special target groups, including men, younger adults, low-income, low-education, and minorities.
- Meet precision and accuracy standards established by the Laboratory Standardization Panel of the National Cholesterol Education Program.
- Include education materials which provide reliable information about cholesterol levels including appropriate follow-up measures based on established cutpoints.
- Insure an environment conducive to effective public screening by providing convenient, efficient screening sites adequate to accommodate screenees and assure quality control procedures.
- Provide an active referral and follow-up program, using letters or phone calls as necessary to ensure that referred screenees achieve medical care.
- Refer screenees to medical care based on the cutpoints established by the NCEP.

The National Heart, Lung, and Blood Institute publication is titled "Report of the Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults". The NIH Publication Number is 88-2925. Material may be requested from NHLBI Education Programs Information Center, 4733 Bethesda Avenue, Suite 530, Bethesda, MD 20814-4820; telephone (301) 951-3260.

"Guidelines for Cholesterol Screening Programs" is a publication of the American Heart Association. Single copies are available at no charge from the Montana Affiliate, 510 First Avenue N., #4, Great Falls, MT 59401, or by calling (800) 447-9442 (in Montana).

Funding Facts

A successful search for funds to support a community project usually contains several aspects: a comprehensive plan of action, support from key persons and organizations, familiarity with sources of funds and an understanding of the various ways to apply for funds.

Preliminary planning and research are essential to a successful proposal. Before applying for funds, consider exploring the following questions:

Why is the program needed? This question can be answered by both formal and informal means. Statistical data, needs assessment, surveys, questionnaires, etc., are likely sources to document the need.

Interviews, observations and program documents might offer substantial data to support the need.

Who in the community supports the program? Building support and alliances with others groups is sometimes called networking. To maximize the chances of achieving a successful, well-funded project, contacts should be established. Support may come in the form of endorsement, collaboration, pooling of resources and minimizing duplication.

Is the project appropriate for your organization? A program should be compatible with the mission and core operations of the organization which offers it.

What groups may supply funds? When searching for funds, it is important to focus on the most likely sources and learn as much about them as possible.

What are the health goals of the funding sources? If the objectives of the project are consistent with these goals, there's a better chance to receive funding!

Is it possible to merge with an existing program? By joining an on going program, a project can build on existing visibility and expertise while minimizing costs by sharing staff and resources.

Source: Locating Funds for Health Promotion Projects, Office of Disease Prevention and Health Promotion, U.S. Dept. of Health and Human Services, 1988.

JUMPING FOR HEART—*Second graders from Hawthorne School in Helena, practiced during February for the Annual "Jump Rope for Heart," to benefit the American Heart Association.*

Resources

Lower Your Blood Pressure and Live Longer, by Marvin Moser, M.D., 290-page book, 1989.

A simple treatment program to control high blood pressure is presented. Information is given to help the public judge the treatment they are receiving. Topics include causes and diagnosis of hypertension; selecting a doctor; tests, procedures and medications; roles of diet, alcohol and tobacco; hypertension in the elderly, pregnant and children; and non-drug and fad treatments.

Available in bookstores or from: Random House, Inc., 400 Hahn Road, Westminster, MD, 21157. $18.95 hardbound.

Eater's Choice Cholesterol Treatment Program

This program is for use by health professionals in helping people lower their cholesterol by recognizing the saturated fat content of foods and controlling the amount in their diet. Patient kit includes the book, "Eater's Choice: A Food Lover's Guide to Lower Cholesterol"; a workbook; and aids for recording fat intake. Professional kit includes a patient kit; leader's guide, slides, self-instruction manual; and audiotape.

Available from Health Prospects, 1801 Rockville Pike, Suite 500, Rockville, MD, 20852. Professional kit, $150; Patient kit, $40. (Plus $6 per kit shipping and handling). Book available separately in bookstores, $11.95 paperback.

Low-Fat, Low-Cholesterol Cookbook, edited by Scott Grundy, MD., Ph.D., for the American Heart Association, 340-page book, 1989.

Contains a wealth of tips about grocery shopping, eating and adapting recipes to eliminate unnecessary damaging fats in our diets, as well as 200 new recipes specifically developed by the AHA for those who need to reduce their cholesterol levels. This cookbook is also a step-by-step guide to lowering cholesterol.

Available in bookstores, $18.95 hardbound.

NHLBI Kit '90: The Right Moves from the National Heart, Lung and Blood Institute.

This kit is a new collection of data, program ideas, resource materials and reproducible handouts for health promotion program planners. This year the kit includes information on blood resources and asthma, as well as hypertension, cholesterol, smoking, stroke and nutrition.

Available from NHLBI Kit '90 Information Center, 4733 Bethesda Ave., Suite 530, Bethesda, MD, 20814-4820, for a $5 per kit handling fee.

Promoting Physical Activity Among Adults is a series of guides that includes tools to evaluate the effectiveness of fitness programs; methods for estimating the health problems associated with a sedentary lifestyle; and information that stresses the importance of regular physical activity for individual and community health.

For information about the guides, contact Dr. Ken Powell, Cardiovascular Branch, Division of Chronic Disease Control, Centers for Disease Control, 1600 Clifton Road, Atlanta, GA, 30333; (404) 639-3158.

Coming Up

March 29-30	**MONTANA DIETETIC ASSOCIATION MEETING,** Great Falls, contact Deb Bjorness, 761-1200.
April 11-13	**MONTANA PUBLIC HEALTH CONFERENCE,** Lewistown, contact MPHA, Bob Moon, 444-4740.
April 27-28	**1990 MONTANA PERINATAL ASSOCIATION CONFERENCE,** Copper King Inn, Butte, contact Kim Nelson, MSU Continuing Education for the Health Professional, 994-4930.
May 3	**SUICIDE, THE PREVENTABLE DEATH,** Deaconess Hospital, Billings, contact Mental Health Association of Montana, Joy McGrath, 442-4276.
May 17-18	**5TH ANNUAL RURAL NURSE CONFERENCE: RURAL NURSING IN THE 90s,** Cavanaugh's Inn, Kalispell, contact Lois McCray, (509) 397-3435.
May 30-June 2	**1990 HEALTHY MOTHERS, HEALTHY BABIES WESTERN STATES REGIONAL CONFERENCE,** Cavanaugh's Motor Inn, Kalispell, contact Kim Nelson, MSU Continuing Education for the Health Professional, 994-4930.
August 12-16	**ROCKY MOUNTAIN HEALTH PROMOTION CONFERENCE,** MSU, Bozeman, contact Kim Nelson, MSU Continuing Education for the Health Professional, 994-4930.

Beyond Disability

by Cecilia Cowie

The internal dynamics of Montana's Secondary Disabilities Prevention Program calls for grass roots state and local health promotion drives for individuals with disabilities. Thus, information on a healthy lifestyle is being made available in various forms. The following is an excerpt from a brochure for individuals with a disability published by the Secondary Disabilities Prevention Program. Copies of the brochure will be available upon request from SDPP, Preventive Health Services Bureau, MDHES, Cogswell Building, Room C314, Helena, MT 59620.

Moving beyond disability means adopting an agressive approach to personal health. Here is a checklist of some essential activities of a healthy lifestyle.

PSYCHOLOGICAL HEALTH

—inform yourself concerning all aspects of your disability
—join or initiate peer counseling groups
—talk to good friends
—find a telephone buddy
—seek professional counseling
—include your family in counseling

SOCIAL HEALTH

—participate in your society
—advocate social progress and civil rights
—go out and have fun
—educate your community as to the realities of disabilities

PHYSICAL FITNESS

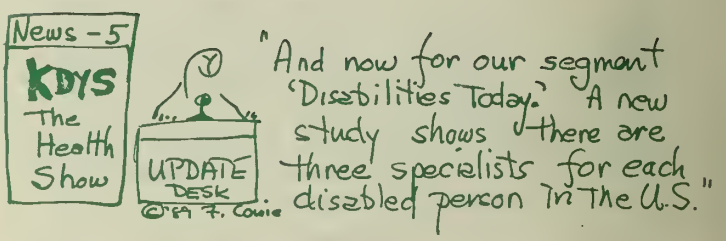
—exercise regularly
—watch your diet
—control your weight
—avoid smoking, drinking, drugs
—have your blood pressure checked regularly
—have regular dental checkups

MENTAL FITNESS

—enroll in an assertiveness training class
—develop positive thinking
—take the initiative in activities
—promote independence of spirit
—advocate self-expression
—help others to help themselves
—familiarize yourself with stress reduction techniques

PREVENTION OF SECONDARY PHYSICAL DISABILITIES

—know what problems you are susceptible to and their early warning signs
—practice injury prevention and "safety first"
—obtain immunization against flu
—get regular physicals
—obtain straight-forward information on all medication


News - 5
KDYS
The Health Show
UPDATE DESK
©'89 T. Cowie
"And now for our segment 'Disabilities Today.' A new study shows there are three specialists for each disabled person in the U.S."

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